08289

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08303

CERTIFICATE OF DEATH

Reg. Dist. No. 57

Item 4, FilmG170A 9-30-54 et

1. PLACE OF DEATH: COUNTY Calvert MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mutual
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Calvert
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mutual
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Edward (Middle) (Last) Boone

4. DATE OF DEATH: (Month) 9 (Day) 7 (Year) 1954

5. SEX: M
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):
8. DATE OF BIRTH: April 20, 1895
9. AGE last birthday 59 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Laborer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Boone
14. MOTHER'S MAIDEN NAME: Bertha Rawlings

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT & ADDRESS: Marion Boone, Mutual Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

IMMEDIATE CAUSE (A) Coronary thrombosis

ANTECEDENT CAUSE (B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Senile dyst & chronic

DUE TO (C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 7, 19 , to Sept 7, 1954, that I last saw the deceased alive on Sept 7, 19 , and that death occurred at 8:34 M, from the causes and on the date stated above.

SIGNATURE R. W. Willavert ADDRESS M. D. St Leonard DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY) DATE THEREOF 9-12-54 NAME OF CEMETERY OR CREMATORY Brooks Chapel LOCATION (City, town, or county) (State) Island Creek, Md

DATE REC'D BY LOCAL REGISTRAR 9-12-54 REGISTRAR'S SIGNATURE H. W. Ward
24. FUNERAL DIRECTOR P. E. Sewell Pr. Fred, Md ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 1953

RECEIVED
SEP 15 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08304

08290

CERTIFICATE OF DEATH

Reg. Dist. No. 52

1. PLACE OF DEATH: COUNTY Calvert MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ches Beach
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Calvert
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ches Beach
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Maurice (Middle) Hunter (Last) Cochran
4. DATE OF DEATH: (Month) 9 (Day) 1 (Year) 1954

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M
8. DATE OF BIRTH: Feb 24 1892
9. AGE last birthday: 62 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Contractor
10b. KIND OF BUSINESS OR INDUSTRY: Plumbing
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Cochran
14. MOTHER'S MAIDEN NAME: Cassie Ann Stinnett

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) yes (If Yes, give war or dates of service) 8/3/17 - 11/30/18
16. SOCIAL SECURITY No.: 218-14-0993
17. INFORMANT & ADDRESS: Mr. Martin Cochran West Beach Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

974X

Immediate cause (a) Strangulation DUE TO

Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Hanging DUE TO

(c)

Interval Between Onset And Death

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Found hanging in pringsteam

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) Suicide
PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) Ches. B. (CITY OR TOWN) Calvert (COUNTY) (STATE) Md
TIME OF INJURY (Month) (Day) (Year) (Hour) 9/1/54 4:30 P.M.
INJURY OCCURED While at Work ☒ Not While At Work ☐
HOW DID INJURY OCCUR? Hung himself

22. I hereby certify that I attended the deceased from ....., 19..... to ....., 19....., that I last saw the deceased alive on ....., 19....., and that death occurred at 5 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) H. Ward D. Mg. ADDRESS Owings Md DATE SIGNED 9/1/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 9/3/54
NAME OF CEMETERY OR CREMATORY Mt. Harmony
LOCATION (City, town, or county) Mt. Harmony (State) Calvert, Md

DATE REC'D BY LOCAL REGISTRAR Burial
REGISTRAR'S SIGNATURE Grace L. Hutchins
24. FUNERAL DIRECTOR Wm. H. Hutchins ADDRESS Owings Md

Sept. 3, 1954

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 8 1954
BUREAU V. S.

08305

MARYLAND 08291

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 51

M

MARGIN RESERVED FOR BINDING

I

1. PLACE OF DEATH: COUNTY Calvert MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural
LENGTH OF STAY (in this place) 5 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Calvert Co Hospital Prince Frederick Md

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Prince George
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt Rainier Md. 16162
STREET ADDRESS (If rural, give location) 4230 - 34st Mt Rainier Md

3. NAME OF DECEASED (Type or Print) (First) Frederick (Middle) Charles (Last) FUNK

4. DATE OF DEATH (Month) Sept (Day) 5 (Year) 1954

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH 5-6-1902
9. AGE last birthday 52 yrs. If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Printing Office
10b. KIND OF BUSINESS OR INDUSTRY Proof Reader
11. BIRTHPLACE (State or foreign country) New York
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Jacob Funk
14. MOTHER'S MAIDEN NAME Mary Dettel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS Mrs F.C. Funk 4230-34st Mt Rainier Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

541.1

Immediate cause (a) Biliary Peritonitis

Antecedent cause(s) (b) Ruptured Duodenal ulcer (closed)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Secondary Pancreatitis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION Aug 31, 1954
19b. MAJOR FINDINGS OF OPERATION Ruptured Duodenal ulcer
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 31, 1954, to Sept 5, 1954, that I last saw the deceased alive on Sept 5, 1954, and that death occurred at 11 a.m., from the causes and on the date stated above.

SIGNATURE Roger Jett (Degree or title) ADDRESS Prince Frederick DATE SIGNED 9/5/54

23. BURIAL, CREMATION, REMOVAL (Specify) Removal
DATE 9-5-54
NAME OF CEMETERY OR CREMATORY Mt. Rainier, Md.
LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG. 9-5-54
REGISTRAR'S SIGNATURE H. W. Ward
24. FUNERAL DIRECTOR Nalley's Funeral Home ADDRESS 3200 R.I. Ave. Mt Rainier

RECEIVED
SEP 10
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08306

08292

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH:
COUNTY Calvert MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick
LENGTH OF STAY (in this place) 28 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Calvert County Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Calvert
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Huntingtown (rural)
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Peter (Middle) (Last) Henrickson

4. DATE OF DEATH: (Month) Sept. (Day) 9, (Year) 1954

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): W
8. DATE OF BIRTH: Oct. 2, 1882
9. AGE last birthday 71 yrs. If under 1 year: Months 11 Days 7 If under 24 hrs.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist
10B. KIND OF BUSINESS OR INDUSTRY: Transit
11. BIRTHPLACE (State or foreign country): Denmark
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) 1904 – 1910
16. SOCIAL SECURITY NO. 213-10-0225
17. INFORMANT & ADDRESS: William Robinson - Huntingtown, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

IMMEDIATE CAUSE (A) Coronary thrombosis

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Hypertension C-V &

DUE TO (C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19...., to Sept 54, 19...., that I last saw the deceased alive on Sept 8, 1954, and that death occurred at 11:35 M, from the causes and on the date stated above.

SIGNATURE R. W. Stewart M. D. ADDRESS S. Thomas DATE SIGNED 9/10/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF Sept. 11, 1954
NAME OF CEMETERY OR CREMATORY Asbury Cemetery
LOCATION (City, town, or county) (State) Barstow - Calvert Co. - Md

DATE REC'D BY LOCAL REGISTRAR 9-10-54
REGISTRAR'S SIGNATURE H. W. Ward
24. FUNERAL DIRECTOR A. A. Harkness & Son - Mutual, Md. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 1[illegible]

RECEIVED
SEP 15 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08307

08293

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH:
COUNTY Calvert MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake Beach
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Calvert
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake Beach, Md
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) William (Middle) (Last) Jones

4. DATE OF DEATH: (Month) 9 (Day) 2nd (Year) 1954

5. SEX: M
6. COLOR OR RACE: C
7. SINGLE, (MARRIED,) WIDOWED, DIVORCED, (Specify):
8. DATE OF BIRTH: Feb 18, 1878
9. AGE last birthday 76 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Owner
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Jones Sr.
14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT & ADDRESS: Drusilla Jones, Chesapeake Beach.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

151X

IMMEDIATE CAUSE (A) Ca of Stomach

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/ 54, 1954, to 9/2, 1953, that I last saw the deceased alive on Sept 1954, and that death occurred at 9:30 P.M, from the causes and on the date stated above.

SIGNATURE R. W. Willard M.D. ADDRESS St Leman DATE SIGNED 9/3

23. (BURIAL,) CREMATION, REMOVAL (SPECIFY) DATE THEREOF 9-5-54 NAME OF CEMETERY OR CREMATORY St Edmonds LOCATION (City, town, or county) (State) Calvert, Md

DATE REC'D BY LOCAL REGISTRAR 9-3-54 REGISTRAR'S SIGNATURE H. W. Ward
24. FUNERAL DIRECTOR P. E. Sewell Prince ADDRESS Fred, Md

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10

RECEIVED
SEP 10 1954
BUREAU V. S.

08294

Items 7,8,10a,10b,11,13,& 14 PHONE CALL FROM FUNERAL DIRECTOR 9/21/54 jst

08308

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. .....

1. PLACE OF DEATH: COUNTY CALVERT MARYLAND

CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) — LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS Solomons Islands Md.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Washington COUNTY D.C.

CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN

STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) ROBERT (Middle) KENNETH (Last) LYBERGER

4. DATE OF DEATH (Month) (Day) (Year) September 6 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): [illegible]

8. DATE OF BIRTH: 3-18-1913

9. AGE last birthday: 41 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Airman

10b. KIND OF BUSINESS OR INDUSTRY: U S. Air Force

11. BIRTHPLACE (State or foreign country): Unk.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unk.

14. MOTHER'S MAIDEN NAME: Gertrude B. Lyberger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Carbon monoxide poisoning

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.,

21c. (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☒.

SIGNATURE William V Lovett M. D.

CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☒

DATE SIGNED Sept. 7, 1954

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF

NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem.

LOCATION (City, town, or county) Arlington (State) Va.

DATE REC'D BY LOCAL REG. 9/7/54

REGISTRAR'S SIGNATURE A.W. Hedrick

24. FUNERAL DIRECTOR Rinaldi Funeral Home ADDRESS

SCL 816-H.N.E. Wash. DC.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A-5-53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08309

08295 CERTIFICATE OF DEATH

Reg. Dist. No. 52

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
COUNTY Calvert
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Owings
LENGTH OF STAY (in this place) 3 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Virginia COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Norfolk 0 J X - 2
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) George (Middle) Thomas (Last) Miller

4. DATE OF DEATH: (Month) Sept. (Day) 21 (Year) 195[illegible]

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: February 2, 1890

9. AGE last birthday: 64 yrs. IF UNDER 1 YEAR Months 7 Days 19 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Salesman

10b. KIND OF BUSINESS OR INDUSTRY: Griffin Bros. Coal Co.

11. BIRTHPLACE (State or foreign country): Regent, Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Gamaliel Thomas Burgess Miller

14. MOTHER'S MAIDEN NAME: Josephine Dunleady

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: 231-09-0146

17. INFORMANT & ADDRESS: Mrs. Ringgold Miller Owings, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

177X

Immediate cause (a) Carcinoma of Prostate DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO

(c)

Interval Between Onset And Death

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/5, 1954, to 9/21, 1954, that I last saw the deceased alive on 9/20, 1954, and that death occurred at 8 PM, from the causes and on the date stated above.

SIGNATURE Eugene Dietz M.D. (Degree or title) ADDRESS Frederick DATE SIGNED 9/22/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF Sept. 24, 1954 NAME OF CEMETERY OR CREMATORY Harmony Grove LOCATION (City, town, or county) Middlesex Co. (State) Virginia

DATE REC'D BY LOCAL REGISTRAR 9/22/54 REGISTRAR'S SIGNATURE Grace L. Hutchins

24. FUNERAL DIRECTOR Walter Brennan ADDRESS Portsmouth, Va.

VS. A15

SEP
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08310

08256

CERTIFICATE OF DEATH

Reg. Dist. No. 52

1. PLACE OF DEATH:
COUNTY Calvert — MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN and give nearest town: Prince Frederick
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Calvert County Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Calvert
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Chesapeake Beach
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) James (Middle) Carter (Last) Ranzie

4. DATE OF DEATH: (Month) September (Day) 8 (Year) 1954

5. SEX: Male — 6. COLOR OR RACE: White — 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Divorced — 8. DATE OF BIRTH: June 3, 1890 — 9. AGE last birthday: 64 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): U.S. Navy — 10b. KIND OF BUSINESS OR INDUSTRY: Retired — 11. BIRTHPLACE (State or foreign country): Virginia — 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Ranzie — 14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes — (If Yes, give war or dates of service) Navy 1910-1939 — 16. SOCIAL SECURITY NO.: — 17. INFORMANT & ADDRESS: Irene Ranzie Chesapeake Beach Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause (a) Cardiac asthma — 24hrs

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Myocarditis — 4yrs

DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/7/54 19..., to 9/8/54, 19..., that I last saw the deceased alive on 9/8/54, 19..., and that death occurred at 1.0m, from the causes and on the date stated above.

SIGNATURE (Degree or title) M. Ranzie Owner — ADDRESS — DATE SIGNED 9/8/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 9/13/54 — NAME OF CEMETERY OR CREMATORY Arlington National Cemetery — LOCATION (City, town, or county) Arlington — (State) Va.

DATE REC'D BY LOCAL REGISTRAR Sept 11, 1954 — REGISTRAR'S SIGNATURE Grace L. Hutchins

24. FUNERAL DIRECTOR W. H. Hutchins — ADDRESS Owings Md.

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08311

08297 **CERTIFICATE OF DEATH** Reg. Dist. No. 57

Item 2, 8, 9, 10b, 17: film G190 9/28/54 — Item 3, FilmG171 10-15-54 et

1. PLACE OF DEATH: COUNTY Calvert MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN St Leonards
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY MONTG.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ~~St Leonards~~ Silver Spring
STREET ADDRESS (If rural give location) 10920 N. H. Ave ~~Md~~ 15X-2

3. NAME OF DECEASED: (Type or Print) (First) George (Middle) Adam (Last) Scofield
4. DATE OF DEATH: (Month) 9 (Day) 23 (Year) 1954

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) W
8. DATE OF BIRTH: Oct 29 ~~1877~~ 76
9. AGE last birthday: ~~76~~ 77 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Personal
10b. KIND OF BUSINESS OR INDUSTRY: Store Service Mgr.
11. BIRTHPLACE (State or foreign country): N.Y.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: R. E. Scofield
14. MOTHER'S MAIDEN NAME: Unknown

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.:
17. INFORMANT & ADDRESS: Mary E. Greeley 4 Mrs. C. C. Gastrock Niece Silver Spring Md

18. MEDICAL CERTIFICATION St Leonards Md

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

450.0

Immediate cause (a) Arteriosclerosis

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Uremia

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Has been sick 3 yrs

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from ....., 19....., to ....., 19....., that I last saw the deceased alive on ....., 19....., and that death occurred at 11.45 PM, from the causes and on the date stated above.

SIGNATURE (Degree or title) St Leonards Md ADDRESS DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) DATE THEREOF 9/20/54 NAME OF CEMETERY OR CREMATORY Fort Lincoln LOCATION (City, town, or county) (State) Wash. DC

DATE REC'D BY LOCAL REGISTRAR 9/24/54 REGISTRAR'S SIGNATURE H. W. Wood
24. FUNERAL DIRECTOR Hines ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 29 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08312

08298 **CERTIFICATE OF DEATH** Reg. Dist. No. .....

1. PLACE OF DEATH: COUNTY Calvert MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lusby (rural) LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Calvert
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lusby (rural)
STREET ADDRESS (If rural give location) —

3. NAME OF DECEASED: (Type or Print) (First) James (Middle) G. (Last) Sollers
4. DATE OF DEATH: (Month) Sept. (Day) 28, (Year) 1954
5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M
8. DATE OF BIRTH: Sept. 15, 1876
9. AGE last birthday 78 yrs. IF UNDER 1 YEAR Months 0 Days 13 IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Owner
10B. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Calvert County Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John J. Sollers
14. MOTHER'S MAIDEN NAME: Catherine Uniack
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) No
16. SOCIAL SECURITY NO. No
17. INFORMANT & ADDRESS: Roger Sollers - Lusby, Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

180X

IMMEDIATE CAUSE (A) Carcinoma of Rt ureter 1853

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) & Pulmonary Tbc March 1954

(002X) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: March 54
19B. MAJOR FINDINGS OF OPERATION: Carcinoma of Rt ureter
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 2, 1954, to Sept 28, 1954, that I last saw the deceased alive on Sept 27, 1954, and that death occurred at ..... M, from the causes and on the date stated above.

SIGNATURE Roger Sett M. D. ADDRESS Bunny Neduck DATE SIGNED 9/28/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
DATE THEREOF: Sept. 1, 1954
NAME OF CEMETERY OR CREMATORY: Middleham Chapel
LOCATION (City, town, or county) (State): Lusby - Calvert Co., Md.

DATE REC'D BY LOCAL REGISTRAR: 9/30/54
REGISTRAR'S SIGNATURE: H. W. Ward
24. FUNERAL DIRECTOR: A. A. Harkness & Son - Mutual, Md. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-

RECEIVED
OCT 4 1954
BUREAU V. S.